Section 3.5 Third Party Liability and Coordination of Benefits

3.5.1 Introduction

Third party liability refers to situations in which persons enrolled in the public behavioral health system also have behavioral health service coverage through another health insurance plan, or "third party". The third party can be liable or responsible for covering some or all the behavioral health services a person receives. Behavioral health providers are responsible for checking if a person has third party health insurance before using other sources of payment such as Medicaid (Title XIX), KidsCare (Title XXI) or State appropriated behavioral health funds.

There are two methods used in the coordination of benefits; cost avoidance and post-payment recovery:

- Cost avoidance-Behavioral health providers must cost avoid all claims or services that are subject to third-party payment and may deny a service to a person if it is known that a third party (i.e., other insurer) will provide the service. However, in emergencies, behavioral health providers must provide the necessary services and then coordinate payment with the third party payer. If a third party insurer (other than Medicare) requires the person to pay any co-payment, coinsurance or deductible, the T/RBHA is responsible for covering these costs for Title XIX/XIX persons. Non-Title XIX/XXI persons must pay any co-payment, coinsurance or deductible of the third party insurer.

- Post-payment recovery is necessary in cases where a behavioral health provider was not aware of third party coverage at the time services were rendered or paid for, or was unable to cost avoid.

The intent of this section is to describe the requirements for behavioral health providers to:

- Determine if a person has third party health insurance coverage before using Federal or State funds;

- Coordinate services and assign benefit coverage to third party payers when information regarding the existence of third party coverage is available; and
- Submit billing information that includes documentation that third party payers were assigned coverage for any covered behavioral health services that were rendered to the enrolled person.

3.5.2 References

The following citations can serve as additional resources for this content area:

- AHCCCS/ADHS Contract
- ADHS/T/RBHA Contract
- A.R.S. § 36-2903 (F)
- R9-22-1001
- R9-22-1002
- R9-22-110
- Co-payments Section
- Accessing and Interpreting Eligibility and Enrollment Information and Screening and Applying for AHCCCS Health Insurance Section
- Intake, Assessment and Service Planning Section
- Covered Behavioral Health Services Section
- Submitting Claims and Encounters Section
- Provider Appeals Section

3.5.3 Scope

To whom does this apply?

All persons seeking enrollment or enrolled in the public behavioral health system.

3.5.4 Did you know…?

- If third party information becomes available to the provider at any time for Title XIX or Title XXI eligible persons, that information must be reported to the AHCCCS Administration, Division of Member Services within 10 days from the date of discovery. AHCCCS has developed a form that can be used to report changes in third party liability. (PM Form 3.5.1)

- The RBHA is responsible for making third party payer information available to all providers involved with the person receiving behavioral health services.

- Third parties include, but are not limited to, private health insurance, Medicare, employment related health insurance, medical support from non-custodial parents, court judgments or settlements from a liability insurer, State worker's compensation, first party probate-estate recoveries, long term care insurance and other Federal programs.

- For those Medicare services that are also covered under Title XIX/XXI, there is no cost sharing obligation if the T/RBHA has a contract with the Medicare provider and the provider's contracted rate includes Medicare cost sharing as specified in the contract.

- Children who qualify for Adoption Subsidy will be eligible for Title XIX benefits. In addition, their families may also have private insurance. Simultaneous use of the private insurance

and Title XIX coverage may occur through the coordination of benefits. Following an intake and assessment, behavioral health providers must determine the services and supports needed. Any necessary services that are not covered through the private insurance, including co-payments and deductibles, may be covered under Title XIX.

3.5.5 Objectives

To establish guidelines for behavioral health providers to determine the existence of third party liability and to coordinate benefits for enrolled persons with third party liability.

3.5.6 Definitions

Third Party Liability

Cost avoidance

Dual eligible

QMB dual

Non-QMB dual

3.5.7 Procedures

3.5.7-A: How do behavioral health providers know if a person has other health insurance coverage?

Behavioral health providers will inquire about a person's other health insurance coverage during the initial intake process (See Section 3.9, Intake, Assessment and Service Planning). When behavioral health providers attempt to verify a person's Title XIX or Title XXI eligibility, information regarding the existence of any third party coverage is provided through the automated systems described in Section 3.1, Accessing and Interpreting Eligibility and Enrollment Information and Screening and Applying for AHCCCS Health Insurance. If a person is not eligible for Title XIX or Title XXI benefits they will not have any information to verify through the automated systems, therefore, the existence of third party payers must be explored with the person during the screening and application for AHCCCS health insurance process.

3.5.7-B: How do behavioral health providers know what services the other health insurance party will cover?

The third party health insurance coverage may cover all or a portion of the behavioral health services rendered to a person. Behavioral health providers must contact the third party directly to determine what coverage is available to the person. At times, T/RBHA may incur the cost of co-payments or deductibles for an eligible person while the cost of the covered service is reimbursed through the third party payer.

3.5.7-C: Billing requirements

Upon determination that a person has third party coverage, a behavioral health provider must submit proper documentation to demonstrate that the third party has been assigned responsibility for the covered services provided to the person. For specific billing instructions,

see Section 6.1, Submitting Claims and Encounters . The following guidelines must be adhered to by behavioral health providers regarding third party payers:

- ADHS/DBHS and the RBHA must be the payers of last resort for Title XIX/XXI covered services. Payment by another state agency is not considered third party and, in this circumstance, ADHS/DBHS and the RBHA are not the payer of last resort.

- Benefits must be coordinated so that costs for services funded by ADHS/DBHS or the RBHA are cost avoided or recovered from a third party payer. Providers must bill claims for any covered services to any third party payer when information on that third party payer is available. Documentation that such billing has occurred must accompany the claim when submitted for payment. Such documentation includes a copy of the Remittance Advice or Explanation of Benefits from the third party payer. The only exceptions to this billing requirement are:

    - When a response from the third party payer has not been received within the timeframe established by the RBHA for claims submission or, in the absence of a subcontract, within 120 days of submission; or
    - When it is determined that the person had relevant third party coverage after services were rendered or reimbursed.

In an emergency situation, the provider must first provide any medically necessary behavioral health covered services and then coordinate payment with any potential third party payers.

Providers must cost avoid all claims or services that are subject to third party payment and may deny a service to a person if they know that the third party payer is financially responsible for providing the service. If the provider knows that the third party payer will not pay for or provide a medically necessary covered service then the provider must not deny the service nor require a written denial letter. If the provider does not know whether a particular medically necessary covered service is covered by the third party payer, they must contact the third party payer rather than requiring the person receiving services to do so.

3.5.7-D: Discovery of third party liability after services were rendered or reimbursed
If it is determined that a person has third party liability after services were rendered or reimbursed, behavioral health providers must identify all potentially liable third party payers and pursue reimbursement from them. In instances of post-payment recovery, the behavioral health provider must submit an adjustment to the original claim, including a copy of the Remittance Advice or the Explanation of Benefits. Providers may not attempt reimbursement for Title XIX and Title XXI persons in the following circumstances, unless the case has been referred to the RBHA by AHCCCS and/or ADHS/DBHS:

- Uninsured/under-insured motorist insurance
- First and third party liability
- Tortfeasors
- Special Treatment Trusts
- Adoptions
- Worker's compensation

- Estates

The behavioral health provider is responsible to report any cases involving the above circumstances to the RBHA. Behavioral health providers may be asked to cooperate with AHCCCS and/or ADHS/DBHS in third party collection efforts.
[RBHA enter specific language here]

3.5.7-E: Co-payments, coinsurance and deductibles

If a third-party insurer (other than Medicare) requires a person to pay a co-payment, coinsurance or deductible, the T/RBHA is responsible for covering those costs for Title XIX/XXI persons. Non-Title XIX/XXI persons must pay any co-payment, coinsurance or deductible of the third party insurer. If a service is necessary, the provider must ensure that its cost avoidance efforts do not prevent a person from receiving the service and that the person will not be required to pay any coinsurance or deductibles for use of the other insurer's providers.

3.5.7-F: Transportation

Behavioral health providers must provide and retain fiscal responsibility for transportation for Title XIX and Title XXI persons in order for the person to receive a covered behavioral health service reimbursed by a third party.

3.5.7-G: Medicare

An AHCCCS person may be eligible for both Title XIX and Medicare. These persons are sometimes referred to as "dual eligibles". In most cases, behavioral health providers are responsible for payment of Medicare coinsurance and/or deductibles for covered services provided to dual eligible persons. However, there are different cost sharing responsibilities that apply to dual eligible persons for a variety of situations. In the event that a Title XIX person also has coverage through Medicare, behavioral health providers must ensure adherence with the requirements described in this subsection.

Persons who are eligible for Medicare benefits can receive services through one of the following arrangements:

- Fee-for-service Medicare system; or
- Enroll in a Medicare Risk Health Maintenance Organization (HMO).

A Medicare Risk HMO is a managed care entity that has a Medicare contract with the Center for Medicare and Medicaid Services (CMS) to provide services to Medicare beneficiaries.

<u>Cost sharing responsibilities for persons enrolled in a Medicare Risk HMO</u>
ADHS/DBHS is the payer of last resort. Therefore, if a behavioral health recipient is enrolled with a Medicare Risk HMO, the behavioral health recipient must be directed to their Medicare Risk HMO. However, if the Medicare Risk HMO does not authorize a Title XIX covered behavioral health service, the **[RBHA or behavioral health provider]** must:

- Review the requested service;
- Determine if the service is a medically necessary covered service; and
- When determined, provide the service.

[RBHA or behavioral health providers] have cost sharing responsibility for all Title XIX covered services provided to behavioral health recipients by a Medicare Risk HMO. For those Medicare services that have benefit limits, the **[RBHA or behavioral health provider]** must reimburse all Title XIX and Medicare covered services when the behavioral health recipient reaches the Medicare Risk HMO's benefit limits.

[RBHA or behavioral health providers] only have cost sharing responsibility for the amount of the behavioral health recipient's coinsurance, deductible or co-payment. **[RBHA or behavioral health providers]** have no cost sharing obligation if the Medicare payment exceeds the **[RBHA or behavioral health providers]** contracted rate for the services. The **[RBHA or behavioral health provider]** liability for cost sharing plus the amount of Medicare's payment must not exceed the **[RBHA's or behavioral health provider's]** contracted rate for the service. With respect to co-payments, the **[RBHA or behavioral health provider]** may pay the lesser of the co-payment or their contracted rate.

QMB duals enrolled in a Medicare Risk HMO
QMB duals are entitled to:

- All Title XIX covered services;
- Medicare Part A covered services; and
- Medicare Part B covered services.

In addition to Title XIX covered services, QMB duals may receive Medicare services that are not covered under Title XIX, or differ in scope or duration. When a behavioral health recipient is enrolled in a Medicare Risk HMO, the **[RBHA or behavioral health provider]** is responsible for cost sharing for Medicare services that are not covered under Title XIX, or differ in scope or duration. These Medicare services include:

- Inpatient psychiatric services (Medicare has a lifetime benefit maximum);
- Other behavioral health services such as partial care; and
- Any services covered by or added to the Medicare Program not covered under Title XIX.

Non-QMB duals enrolled in a Medicare Risk HMO
[RBHA or behavioral health provider] is responsible for cost sharing for Title XIX only covered services for Non-QMB duals.

Prior authorization for persons enrolled in a Medicare Risk HMO
If the RBHA's contract with a behavioral health provider requires the behavioral health provider to obtain prior authorization before rendering services and the behavioral health provider does not obtain prior authorization, the RBHA is not obligated to pay the Medicare cost sharing for Title XIX covered services, except for emergency services. Exceptions exist for pharmacy and other physician ordered services as described later in this subsection.

If the Medicare Risk HMO determines that a service is medically necessary, the **[RBHA or behavioral health provider]** is responsible for Medicare cost sharing, even if the **[RBHA or behavioral health provider]** determines otherwise. If the Medicare Risk HMO denies a service

requiring prior authorization for lack of medical necessity, the **[RBHA or behavioral health provider]** must apply its own authorization criteria and may not use the Medicare Risk HMO's decision as the basis for denial.

Out of network services for persons enrolled in a Medicare Risk HMO
If an out of network referral is made by a contracted behavioral health provider and the RBHA specifically prohibits out of network referrals in the provider contract, then the behavioral health provider may be considered to be in violation of the contract and the RBHA has no cost sharing obligation. The behavioral health provider who referred the behavioral health recipient to an out of network provider is obligated to pay any cost sharing. The behavioral health recipient must not be responsible for the Medicare cost sharing, unless the behavioral health recipient has been advised of the RBHA's network and elects to go out of the network. In this case, the behavioral health recipient is responsible for paying the Medicare cost sharing amount, unless the service is an emergency, pharmacy or other physician ordered service (see information described later in this subsection).

If the Medicare Risk HMO and the RBHA have networks for the same service that have no overlapping providers and the RBHA chooses not to have the service performed in its own network, then the RBHA is responsible for cost sharing for that service. If the overlapping providers have closed their panels and the behavioral health recipient goes to an out of network provider, then the RBHA is also responsible for cost sharing.

Pharmacy and other physician ordered services for persons enrolled in a Medicare Risk HMO
The requirements described under this heading are for information purposes only. Behavioral health providers may or may not have direct responsibilities related to these activities.

For purposes of this subsection, "in the RBHA network" refers to the provider who supplies the prescription, not the prescribing provider. RBHAs must cover pharmacy co-payments for medications prescribed by both contracted and non-contracted providers as long as the prescriptions are filled at a contracted pharmacy. However, if a provider prescribes a non-formulary medication, then the RBHA may opt to not reimburse for the prescription co-payment. If a RBHA requires prior authorization for formulary medications, then the RBHA may choose not to cover the co-payment if prior authorization was not obtained.

If a behavioral health recipient exceeds their pharmacy benefit limit, the RBHA must cover all prescription costs for the person. These prescriptions are subject to the RBHA's formulary, prior authorization and pharmacy network requirements.

If the Medicare Risk HMO does not offer a pharmacy benefit, then the RBHA may require that the prescribing physician be in the RBHA's network for prescription benefit coverage. This requirement extends to all prescribed services (e.g., laboratory services).

Cost sharing responsibilities for persons under the Medicare fee-for-service program
A Medicare beneficiary may elect to receive Medicare services through providers authorized to deliver Medicare services. **[RBHAs or behavioral health providers]** have cost sharing responsibility for Title XIX covered services provided to behavioral health recipients by fee-for-service behavioral health provider in the RBHA's network. **[RBHAs or behavioral health**

providers] have no cost sharing obligation if the Medicare payment exceeds the **[RBHA's or behavioral health provider's]** contracted rate for the services. The **[RBHA's or behavioral health provider's]** liability for cost sharing plus the amount of Medicare's payment must not exceed the **[RBHA's or behavioral health provider's]** contracted rate for the service. For those Medicare services for which prior authorization is not required but are also covered under Title XIX, there is no cost sharing obligation of the RBHA has a contract with the provider and the provider's contracted rate includes Medicare cost sharing as specified in the contract.

QMB duals receiving services under the Medicare fee-for-service program
QMB duals are entitled to:

- All Title XIX covered services;
- Medicare Part A covered services; and
- Medicare Part B covered services.

[RBHA or behavioral health provider] is responsible for the payment of the Medicare deductible and coinsurance for Title XIX covered services. In addition to Title XIX covered services, QMB duals may receive Medicare services that are not covered under Title XIX, or differ in scope or duration. The services must be provided regardless of whether the behavioral health provider is in the RBHA's network. These Medicare services include:

- Inpatient psychiatric services (Medicare has a lifetime benefit maximum);
- Other behavioral health services such as partial care; and
- Any services covered by or added to the Medicare Program not covered under Title XIX.

Non-QMB duals receiving services under the Medicare fee-for-service program
[RBHA or behavioral health provider] is responsible for the payment of the Medicare deductible and coinsurance for Title XIX covered services that are rendered on a fee-for-service basis by a Medicare behavioral health provider within the RBHA's network. **[RBHAs or behavioral health providers]** are not responsible for Medicare services not covered under Title XIX.

Prior authorization for persons receiving services under the Medicare fee-for-service program
If the RBHA's contract with a behavioral health provider requires the behavioral health provider to obtain prior authorization before rendering services and the behavioral health provider does not obtain prior authorization, the RBHA is not obligated to pay the Medicare cost sharing for Title XIX covered services, except for emergency services. The RBHA cannot require prior authorization for Medicare only services.

If the Medicare provider determines that a service is medically necessary, the **[RBHA or behavioral health provider]** is responsible for Medicare cost sharing, even if the **[RBHA or behavioral health provider]** determines otherwise. If Medicare denies a service requiring prior authorization for lack of medical necessity, the **[RBHA or behavioral health provider]** must apply its own authorization criteria. If the criteria supports the provision of the service, the **[RBHA or behavioral health provider]** must cover the cost of the service.

Out of network services for persons receiving services under the Medicare fee-for-service program

If an out of network referral is made by a contracted behavioral health provider and the RBHA specifically prohibits out of network in the provider contract, then the behavioral health provider may be considered to be in violation of the contract and the RBHA has no cost sharing obligation. The behavioral health provider who referred the behavioral health recipient to an out of network provider is obligated to pay any cost sharing. The behavioral health recipient must not be rersponsible for the Medicare cost sharing, unless the behavioral health recipient has been advised of the RBHA's network and elects to go out of the network. In this case, the behavioral health recipient is responsible for paying the Medicare cost sharing amount, unless the service is an emergency, pharmacy or other physician ordered service (see information described later in this subsection).

Pharmacy and other physician ordered services for persons receiving services under the Medicare fee-for-service program

The requirements described under this heading are for information purposes only. Behavioral health providers may or may not have direct responsibilities related to these activities.

RBHAs must cover prescriptions and other ordered services that are both prescribed and filled by in network providers. If a provider prescribes a non-formulary prescription, then the RBHA may opt to not reimburse for the prescription. The RBHA may also require prior authorization.

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